Ministry of Community and Social Services
Ministry of Children and Youth Services

Ontario

PROVINCIAL TRANSITION PLANNING FRAMEWORK

TRANSITION PLANNING FOR YOUNG PEOPLE WITH DEVELOPMENTAL DISABILITIES

The MCYS/MCSS Provincial Transition Planning Framework is a first step toward improving transition planning for young people with a developmental disability. It is a planning tool that MCYS and MCSS regional offices will use to develop regional protocols with community stakeholders. The protocols will identify community organizations which will work together to support youth with developmental disabilities in developing their transition plan to adulthood. The framework may be revised in the future based on feedback and community experience.

May 2011 Draft

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PREFACE

The Ministries of Community and Social Services and Children and Youth Services are working in partnership to improve transition planning for young people with developmental disabilities.

To this end, the ministries have introduced a Framework for developing regional protocols that formalize transition planning responsibilities between the ministries and among service providers and other community entities. It is a goal of the Framework that transition planning will be provided for young people with developmental disabilities and that planning will begin early.

It is a shared vision of the ministries that transition planning supports provide young people with a smooth transfer to adult services and a good transition experience.

The project detail for implementing the Framework directions is described in a complementary document of **Implementation Instructions**. The instructions set out the phased approach for achieving Framework goals with a focus on actions to be undertaken in 2011.

INTRODUCTION

Transition planning for young people with developmental disabilities can be complicated and complex. The lack of planning and inadequate transition support were described as "one of the most important issues for discussion" by families and individuals in the 2006 report on the transformation consultations [1].

The framework advances a more systematic, coordinated, and transparent approach to supporting young people with developmental disabilities who are preparing for their transition to adulthood, which may include services and supports from the adult developmental services system. Framework goals for promoting effective planning and smooth transitions are underpinned by the following key policy directions:

- Every young person with a developmental disability who requests or will request adult developmental services upon reaching age 18[2] will have a unique transition plan based on assessed needs, eligibility criteria and available resources, and guided by the young person's interests, preferences and priorities.

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[1] November 2006 Summary Report on DS Consultations for Transforming Supports in Ontario for People who have a Developmental Disability (prepared for the Ministry of Community and Social Services)

[2] Most young people leave children's services funded by the Ministry of Children and Youth Services at age 18.

- Planning for the young person's move from children's services will begin early. Preparing a young person for the transition to adulthood should begin at age 14 years (or earlier). Planning should begin in earnest when the young person turns age 16, including preparing to apply for adult developmental services, where appropriate.

CONTEXT

The *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008* sets out the process that a person would need to follow to apply for services and supports for adults with developmental disabilities. The section of the Act relating to the new application process will be proclaimed on July 1, 2011. While the Act refers to services and supports being provided in accordance with need, it also states that provision of services and supports is subject to available resources under the Act. The Act also makes reference to waiting lists for services and supports and does not guarantee service availability.

PURPOSE OF THE FRAMEWORK

The purpose of the Framework is to guide the development of transition planning protocols across the province. The Framework sets out expectations for regional protocols that clearly define planning processes and assign responsibilities for developing and implementing individual transition plans.

- Each ministry regional office[3] will lead a collaborative community process for developing transition planning protocols.

- Regional protocols will establish transparent and consistent processes for preparing young people for leaving children's services, reviewing adult service choices and, where appropriate, applying for adult services and supports for persons with developmental disabilities.

- People will know who is responsible for leading and supporting transition planning in their community. Protocols will clearly describe the responsibilities and leadership expected of service agencies and providers in both the children's and adult service sectors, and the contributions of other parties for supporting individual transition planning.

- Regional protocols will include all appropriate health and community service sectors.

- Regional protocols will be accessible and publicly available. Parents, guardians and other interested individuals will be able to easily access information about transition planning processes.

[3] Regional offices of the Ministry of Community and Social Services and the Ministry of Children and Youth Services.

KEY OBJECTIVES

Young People and their Families

- Young people and their families will have better access to information about the full range of service and support options, including other community and health services and supports and residential options, improved planning for service continuity at transition and more control over decisions that affect the young person and his or her family.

- Every young person with a developmental disability who may request adult services will understand how to apply for adult developmental services and supports.

- The transition experience of young people and their families will be improved through a clear and transparent transition planning process that looks at the changing needs of young people and helps them transition to appropriate adult systems of support and community participation.

- Every young person with a developmental disability will have a transition plan that documents his or her transition goals, support needs and the process by which to achieve the transition.

- A purpose of a regional protocol is to identify, for parents, guardians and young people with developmental disabilities, the people responsible for leading and supporting transition planning in their community (for example, children's service providers will be required to identify transition age clients and initiate the planning process on their behalf). Protocols will not require a parent or guardian to initiate the transition planning process for their child. However, the protocol must provide young people and their parents or guardian, or other people important to the young person, with opportunities to actively participate in and contribute to transition planning.

Service Agencies and the Broader Community

- Ministry regional offices will work with their communities engaging young people and adults with developmental disabilities, their families and advocates, children's and adult agencies and other community entities to establish consistent and transparent protocols to support transition planning.

- The transition planning protocols will incorporate best practices for successful transitions, including an early start to planning and the involvement of the young person, and his or her family members or guardian in the planning.

GOVERNMENT AND "COMMUNITY" ROLES

Role of the Ministry of Community and Social Services and the Ministry of Children and Youth Services:

The Ministries of Children and Youth Services (MCYS) and Community and Social Services (MCSS) and are working together to support improved transition planning for young people with developmental disabilities. In partnership, the ministries will:

- Provide overall policy direction and develop tools to support the implementation of the Framework and monitor the progress made towards achieving its goals.

- Share a duty of oversight functions so that the actions and activities required to develop and implement protocols are carried out.

- Develop policies and resource planning strategies (e.g. best practices to develop policy and resource planning) to support successful transition planning.

- Engage and collaborate with other ministries on inter-ministerial systems approaches for supporting transitioning young people with developmental disabilities who will require adult accommodation, health services and community services and supports, and/or educational or vocational training.

The ministries are not involved in the determination of any person's eligibility for adult services nor do they approve or otherwise influence the type and amount of services that may be provided to a person. The ministries do not carry out or participate in any activities that are typically defined as case management. As described below, the confirmation of eligibility for adult developmental services are made by Developmental Services Ontario (DSO) organizations, located in communities across Ontario.

Role of Service Providers, Service Agencies and Developmental Services Ontario Organizations (Adult DS)

- Children's service agencies will participate in and contribute to transition planning on behalf of young people with developmental disabilities who receive agency services.

- Representatives from the adult developmental services system will participate in and contribute to transition planning.

- Adult service agencies may be requested to contribute information about their services.

- The transition planning expectations and accountabilities of service provider agencies for developing transition plans will be defined in regional protocols and set out in future service agreements.

- DSO organizations designated under the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008* will provide a single point of contact for people with enquiries about services and supports for

adults who have a developmental disability and will be the point for access to publicly-funded developmental services and supports for adults in Ontario.

- The designated DSO organizations will be up and running on July 1, 2011[4].

- Upon request, DSO organizations will provide information to the transition planning team on the services and supports that may be provided by community agencies in its geographic service area.

- Upon request, DSO organizations will provide information about the eligibility criteria and application process for developmental services and supports to the transition planning team. The Application for Developmental Services and Supports (ADSS) will collect information about the individual's personal goals, accomplishments, dreams, wishes, preferences and needs, current supports in place such as members of a circle of support and support services, specific information on the individual's communication style and needs, specialized medical needs and equipment, and other background data.

- DSO organizations will assess the support needs of individuals who are eligible for adult developmental services and supports. The Supports Intensity Scale (SIS) is a standardized assessment tool that measures the pattern and intensity of supports needed for adults with a developmental disability, published by the American Association of Intellectual and Developmental Disabilities (AAIDD). The SIS evaluates the pattern and intensity of supports needed in six life activity domains and protection and advocacy activities, as well as medical and behavioural support needs. In addition, the SIS directly assesses support needs by asking about the type, frequency and intensity of supports the individual would need to participate in various life activities as a typical adult in the community.

[4] For information about the DSO organizations, please contact your regional office.

POLICY DIRECTIONS

TRANSITION PLANNING FOR YOUNG PEOPLE WITH DEVELOPMENTAL DISABILITIES

POLICY DIRECTIONS

Supporting Successful Transition Planning for Adult Developmental Services

Developing Individual Transition Plans

- Every young person with a developmental disability will have a written transition plan. A purpose of the plan is to help the young person prepare for adulthood and to plan for adult services in a manner that promotes social inclusion, greater self reliance and as independent a life as possible.

- Planning will begin at age 14 or earlier to provide young people with the information and support they need to prepare for the eventual transition from childhood caregivers to adult community supports and develop the skills they will need to function as an adult. Accelerated preparations to obtain the documentation needed to support a confirmation of eligibility for adult developmental services and supports will begin once the young person turns age 16.

- The transition plan will identify the tasks that need to be completed, the information that must be provided and the individuals responsible for completing each aspect of planning. The plan will be reviewed and updated at least annually.

- The young person, his or her parent or guardian, and individuals identified by the young person will be provided with opportunities to actively participate in and contribute to the development of a transition plan.

Transition Plan

- For the purposes of the protocol, the transition plan is a written plan that helps the young person prepare for adulthood and the transition from child-centred services to adult community supports in a considered and coordinated manner.

- The plan is an evolving and individualized tool. The plan will identify opportunities for progressively increasing the young person's independence and ability to function in adult settings and for preparing parents or guardians and other family members for changes. The plan may consider and address all areas of change including, but not limited to, income support, community inclusion, adult services, living arrangements, adult training and supportive employment or voluntary work experience.

- The plan for the young person who may request adult developmental services and supports upon reaching age 18 will include preparations for making an application for adult developmental services and supports.

- The process for applying for adult developmental services and supports is set out in the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008*, and the eligibility criteria are set out in this Act and its regulation.

Regional Planning Protocols

- Each ministry regional office will lead the development of an MCSS-MCYS transition planning protocol for their service area, based on the Framework.

- Regional protocols will be developed through a collaborative and consultative process. Invited participants will include, but not be limited to, young people with disabilities, parents or guardians and other family members, children's service providers, including children's treatment centres, local children's aid societies, children's mental health agencies and representatives from the adult developmental services system. As well, engagement activities will involve other interested community organizations and individuals, including associations representing local businesses and employers that may be interested in training and employing people with developmental disabilities.

- The finalized protocols will specify local planning procedures and define the expectations of service providers and other entities or individuals for creating or contributing to individual transition plans.

- Requirements of service agencies for participating in and contributing to transition planning on behalf of clients, in accordance with the regional protocol, will be set out in service agreements with the ministry.

- Local protocols will be updated to incorporate all future program and policy directives and service planning or assessment tools issued or authorized by the Ministry of Community and Social Services, including the Supports Intensity Scale (SIS) and the Application for Developmental Services and Supports (ADSS).

- The completed protocols will be publicly available and in formats that are accessible and easily understood by the parents and guardians of young people with developmental disabilities.

GUIDING PRINCIPLES

The intention of the following principles is to promote and support the progression to transition planning best practices.

Planning [5]

Transition planning is a dynamic and continuous process, accommodating changes in personal preferences, conditions and circumstances.

The planning process considers all available and conceivable service scenarios.

There is sufficient flexibility to adapt plans to accommodate or respond to changes in the person's situation or circumstances or changes in the person's needs and priorities.

Transition planning begins early, and continues until the transition is completed (which, for some young people, may be past age 18).

Transition planning is important because it is a means for centering planning on the needs of the young adult and informing them of adult service choices and application processes.

Definition of responsibilities

The responsibilities of all parties to develop and implement individualized transition plans are clearly and explicitly outlined and the intended populations are clearly defined.

Transition planning processes and progress are documented for each individual, with regular communication among involved agencies and individuals during the transition period.

The planning process is conducted in a manner that is respectful of the young person's autonomy and safeguards his or her rights respecting privacy and confidentiality, and capacity and consent.

Person-centred

The person is involved in the planning process and, as much as possible, decisions about his or her care and services are driven by his or her needs, preferences, interests and strengths.

A transition planning goal is to support the young person in ways that help him or her live in the community, maintaining and strengthening the young person's connections with

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[5] In the adult developmental services system, the availability of services to an individual who is eligible for adult developmental services depends on available resources.

parents, siblings and relatives, foster families and any other individuals who are important to the person, as well as connections with his or her community, culture and religion.

The planning process provides the person with choices to support the development of self-determination and self-advocacy.

Information on developmental services and supports, and on other social and health programs and services, is readily available and provided in accessible locations and formats.

Transition planning includes the involvement of individuals who are important to the young person, as determined by the young person.

Transitional arrangements are implemented at a pace that takes into account the needs and preferences of the young person and in a manner that best promotes and preserves service consistency and quality.

Service decisions consider the course of action that is least disruptive to the person.

Collaboration

Information sharing and communication among service agencies and the ministries are integral to developing a coordinated service plan to support transition[6], subject to any applicable legal requirements or restrictions.

[6] Personal information, including personal health information, is shared with the consent of the young person or his or her legal guardian or substitute decision maker.

Regional Protocols

Each regional office will develop an MCYS-MCSS transition planning protocol in collaboration with their communities, including community agencies, young people and their parents or guardians, and other interested individuals and organizations.

Design Assumptions

The most important and enduring aspects of planning should be set out in the protocol. The protocol will describe the transition planning process and clearly define the roles and responsibilities of service agencies and other community entities involved in the transition planning process.

Age of Transition

The protocol applies to the young person who, because of a developmental disability[7] and possibly other medical or physiological conditions, receives children's services and is preparing for his or her transition to adulthood. Planning and preparing young people for adulthood and the move from children's services will begin early (age 14) and accelerated preparations will begin at age 16.

Key Elements of a Protocol

The following guidelines include design elements and best practices that contribute to better transition planning and successful transition plans.

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[7] The definition of "developmental disability" set out in the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008* will be proclaimed into force on July 1, 2011.

PROTOCOL DESIGN ELEMENTS	
Outcomes	**Definitions**
1. IDENTIFY THE YOUNG PERSON WHO WILL BE TRANSITIONING	
Young people at the age of transition are appropriately identified, in a timely manner.	• Identify the young person who will be transitioning. Specify the entities (children's service provider agency or other entity) responsible for identifying young people at age 14 who will likely request adult services. For example, in cases where the young person is receiving an MCYS funded service, the service provider would be responsible for initiating planning (as set out in the protocol and the service agreement). • Assign responsibilities for initiating arrangements for transition planning on behalf of the young person. • Specify the entity or person who will receive and act on this information (i.e. who has lead role in setting up the transition planning team) and the expected actions. • A person with a developmental disability does not have to receive an MCSS or MCYS funded children's service to receive planning assistance. The young person can self-identify his or her need or desire for a plan and other individuals can identify a young person who may benefit from transition planning (parent or guardian, foster parent, teacher, social worker, case worker, health care provider, etc.).
2. IDENTIFY THE TRANSITION PLANNING TEAM	
Individual transition plans identify who is responsible for specific tasks.	• Specify expectations for establishing a planning "team" to participate in and contribute to a person's transition plan. • Provide guidance on the composition of the team (e.g., service providers currently involved with the young person's care and support, a parent or guardian, including the children's aid society in the case of a person in care, as well as other individuals who are important to the young person, school personnel, individuals who are expert in specialized assessment, peer mentors). • Specify the individuals on the planning team and their obligation to provide the young person, his or her parent or guardian[8] and any other person who is important to the young person with opportunities to actively participate in and contribute to the planning process.

[8] For the purposes of this paper, "guardian" includes the children's aid society, where the young person is a person in care.

PROTOCOL DESIGN ELEMENTS	
Outcomes	**Definitions**
	• The size and composition of the team may vary depending on a person's circumstances, preferences and the complexities of his or her service and support needs. The principal expectation is that individuals with the knowledge and expertise needed to develop an appropriate and safe transition plan are involved in the planning. This may include other professional disciplines or service sector providers where indicated by a person's condition or circumstance. • Identify an individual who will assist the young person and his or her parents or guardian throughout the transition planning process (key contact). A single person should act as a "navigator" or "coordinator" on behalf of the young person to facilitate information sharing. Specify expectations for selecting and/or identifying an individual to lead or coordinate the planning process. • Specify expectations for assigning responsibilities for coordinating, scheduling and managing meetings, documenting decisions, safeguarding transition documents (e.g., assessments, support or care records, meeting notes), information gathering (finding resources and services) and for resolving conflicts.
Transition planning includes people who are important to the young person. The young person is supported or represented by a person, or people, who have the willingness, capacity and ability to act in his or her best interests.	• A young person can decline an invitation to participate in planning, however the invitation and opportunity to participate should be repeated at reasonable intervals (e.g., at six month intervals,) unless inadvisable because of the young person's condition or circumstances and the reasons are documented. • The young person, and people identified by the young person - parent or guardian or others - will be provided with opportunities to participate in and contribute to the development of a transition plan. • The protocol will include a plan for managing situations where the young person's parent or legal guardian or substitute decision maker demonstrates little or no interest in participating in or contributing to transition planning.
Transition planning begins early.	• Adult service sector agencies, including the appropriate DSO organization, are involved and engaged early in transition planning for a young person. • The protocol specifies the expectations and obligations of children's service providers and individual adult service agencies (including DSO organizations and/or multi-agency tables with service planning responsibilities) for participating in planning and for contributing assistance and guidance. • Anticipating the mandated duties of DSO organizations, specify expectations for providing information (when the young person is 16) on: adult services and supports, documentation required to support a confirmation of eligibility, and preparations for applying for adult developmental services and supports.

PROTOCOL DESIGN ELEMENTS	
Outcomes	**Definitions**
3. COLLECT INFORMATION TO SUPPORT PLANNING – COORDINATE CROSS SECTOR PLANNING	
Every transitioning young person has a plan for continuing services in the adult service sector. Transition planning processes are coordinated and integrated and information is shared across sectors Good connections between school services and community services – promote collaborative planning. The collection and sharing of personal information is carried out in accordance with Ontario's privacy legislation.	• Specify expectations for gathering, sharing and contributing information for the plan. • The transition planning process is coordinated with the planning processes established by public school boards for transitioning students with developmental disabilities. • With the consent of the young person or his or her parent or guardian, a transition plan that is part of a young person's Individual Education Plan (IEP) is considered in the development of a transition plan for adult services. • The protocol supports a move towards integrating transition planning processes with the transition planning processes of local school boards. • Transitioning young people with a serious or chronic health condition and/or mental health condition, in addition to a developmental disability, will require continuing health care from adult health services. Transition planning protocols will describe a plan for engaging adult health services, where indicated by a person's health condition.
4. DEVELOP THE PLAN	
All transition plans are individualized and based on a person's assessed needs and preferences. The views of the young person are actively obtained and considered in the planning process.	• Specify expectations of the planning "team" or others for developing transition plans in a manner that is consistent with the spirit and purpose of the guiding principles. • Assign the task and activity responsibilities of "team" members, including specifying the contributions expected of team members for specific contributions to planning. • Assign the task of assisting the young person (or parent or guardian) in applying for income and employment supports under the Ontario Disability Support Program (application made at least six months before the person's 18th birthday).

PROTOCOL DESIGN ELEMENTS	
Outcomes	**Definitions**
The young person is assisted to understand the transitioning process and potential options for services and other supports. The young person has the opportunity to express his or her choices in terms of the kinds of services and supports he or she receives and how and where they are provided.	• Transition planning includes the use of the Supports Intensity Scale (SIS) and the Application for Developmental Services and Supports (ADSS) where a young person wishes to apply for these services. • Consider all available resources and arrangement possibilities. Assign a high priority to meeting the preferences of the transitioning young person or the person acting on behalf of the young person, including housing options and community services other than, or in addition to developmental services and supports. • Transition planning recognizes the requirements of the *French Language Services Act*, and reflects ethno-cultural diversity and language with processes that support the needs and preferences of First Nations and other Aboriginal people and ethno-cultural minorities for culturally and linguistically appropriate and sensitive services and supports.
Transition plans include preparations for building the skills the person needs to transition successfully.	• Consider strategies that will help the young person and his family prepare for the move from children's services and the transition to adulthood and a different system of supports and services.
Rights of consent and protection of privacy are paramount. Protocols contain specific procedures to support compliance with legislated safeguards, including the laws respecting consent and substitute decision-making.	• People with developmental disabilities have the same protections in law as other Ontario citizens. • The protocol recognizes legislated protections and demonstrates an understanding of how these laws affect the provision of funding and services to persons with developmental disabilities.
Transition plans identify steps to be taken to manage contingencies.	• Anticipate and specify procedures for managing contingencies (e.g. a significant delay in receiving a needed service). • Assign specific duties to manage situations that affect planning (e.g., arranging cross-sector involvement in planning, determining who will act as the facilitator or coordinator to work with the person throughout the transition process if no other individual is identified).

PROTOCOL DESIGN ELEMENTS	
Outcomes	**Definitions**
Steps to be taken if participants are unable to develop an appropriate plan.	• Specify the process for resolving any differences that cannot be managed by the planning team. • Specify the actions to be taken if the planning team for a transitioning person is unable to agree on the components of a plan or where the team agrees that the complexities of a person's service or care needs exceed the expertise of the team.
Complaints resulting from the transition planning process are minimized or reduced.	• Describe the process for receiving and addressing complaints about the planning process, including complaints that concern the young person's experience of the planning process or that of the parent or guardian.
5. REVIEW AND UPDATE THE PLAN	
Transition plans reviewed and updated on a regular basis.	• Individual transition plans need to be reviewed and updated on a regular basis. • The protocol will include procedures for reviewing, evaluating, updating and revising the plan at specified intervals. • Specify expectations of the planning team for determining a schedule for reviewing and updating the person's plan. A person's plan should be reviewed yearly, at a minimum, and more frequently if warranted by new information and/or the person's circumstances or condition changes.

PROTOCOL DESIGN ELEMENTS	
Outcomes	**Definitions**
6. IMPLEMENT THE PLAN	
The young person is prepared for applying for adult services and supports for persons with a developmental disability. The transition plan sets out the actions to be taken and identifies the individuals with responsibility for taking action. Identified staff welcome and support the transitioning young person. The move from children's services is planned and coordinated.	• The finalized plan describes a coordinated and planned approach for supporting the person's transition to adult community supports. • The plan specifies actions to be taken to initiate and carry out the plan, identifies the people responsible for taking action and specifies the timelines for action.
7. EVALUATION	
Evaluate the transition protocol	• Establish a process for monitoring, evaluating and improving the quality of the planning process and the effectiveness of the protocol in supporting successful transition planning. • Specify processes for reviewing the results of evaluations and revising the protocol based on the findings (at least annually).

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